XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
JOSEPH F. MCKENNA III
Deputy Attorney General
State Bar No. 231195
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9417
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **DAVID JAMES SMITH, M.D.** **3703 Camino Del Rio South, Suite 210** **San Diego, California 92108** **Physician's and Surgeon's License No. G66777,** Respondent.	Case No. 800-2015-013651 OAH No. 2018-080617 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, and not otherwise.

2. On or about August 21, 1989, the Medical Board issued Physician's and Surgeon's Certificate No. G66777 to David James Smith, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on January 31, 2021, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in relevant part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(d) Incompetence.

" ..."

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

////

////

7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

8. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

9. Section 4022 of the Code states:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

////

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent has subjected his Physician's and Surgeon's Certificate No. G66777 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b), of the Code, in that Respondent committed gross negligence in his care and treatment of patients A, B, C, and D,[1] as more particularly alleged hereinafter:

11. **Patient A**

(a) Since at least 2010, Patient A treated with Respondent for pain management due to chronic pain in her back, leg, knee, and shoulder.[2] In or around that time, Patient A already had an intrathecal pump[3] implanted. In or around 2012 and 2013, Respondent implanted multiple new intrathecal pumps in Patient A due to various medical issues.

////

[1] Letters A, B, C, and D are used for the purposes of maintaining patient confidentiality.

[2] Conduct occurring more than seven (7) years from the filing date of the initially filed Accusation (April 27, 2018) involving Patient A is for informational purposes only and is not alleged as a basis for disciplinary action.

[3] An intrathecal pump is a medical device used to deliver medication directly into the space between the spinal cord and the protective sheath surrounding the spinal cord for targeted drug delivery. An intrathecal pump delivers medicine directly into the Cerebrospinal fluid and requires a significantly smaller amount of medication compared to systemically taken (orally) medication due to bypassing the systemic path that oral medication must travel in the body. An intrathecal pump is programmable and it stores the information about medication in its memory. An intrathecal pump is programmed to slowly release medication over a period of time and can be programmed to release different amounts of medication at different times of the day. When the intrathecal pump's reservoir is empty, the medication is refilled by insertion of a needle through the skin and into the fill port on top of the pump's reservoir.

(b) From in or around 2011 to in or around 2017, Respondent managed Patient A's pain medication through intrathecal drug therapy and high dose systemic (oral) opioid drug therapy. During this same time frame, Respondent routinely filled Patient A's intrathecal pump with massive doses of controlled pain medication and routinely prescribed excessive doses of oral opioids and other controlled substances. Significantly, the potent and highly addictive medications from the combined drug therapies (intrathecal and systemic/oral) were being taken by Patient A at the same time, as prescribed by Respondent. In fact, Respondent, notwithstanding Patient A's intrathecal drug therapy, routinely prescribed excessive amounts of oral opioid medication that often exceeded well more than three hundred (300) morphine milligram equivalents (MME) in a day. Respondent prescribed these massive oral doses of opioids to Patient A on multiple dates including, but not limited to, October 2, 2017; July 25, 2016; September 4, 2013; and November 7, 2012.

(c) On or about October 2, 2012, Respondent replaced Patient A's existing intrathecal pump with a newer model.[4]

(d) On or about October 9, 2012, Respondent filled Patient A's newly installed pump with medication but failed to clearly and accurately document the concentration of initial medication that was used to fill the pump. According to the chart note for this outpatient visit, Respondent initiated the pump's medication with an extremely high amount of fentanyl.[5] Patient A's initiating fentanyl dose was documented at a concentration of 25 milligrams (mg) per milliliter (mL), with a

[4] A pump implant operative note indicated that Respondent implanted the Medtronic Synchromed II.

[5] Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. Fentanyl is a potent synthetic opioid drug used as an analgesic and anesthetic. Fentanyl is "approximately 100 times more potent than morphine and 50 times more potent than heroin as an analgesic." (Drugs of Abuse, Drug Enforcement Administration (DEA) Resource Guide (2017 Edition), at p. 40.)

starting dose of 2.499 mg of fentanyl per day. The chart note for this visit also documented filling the pump with Marcaine 5 mg/mL. The chart note further documented that Patient A was continuing to orally take Methadone[6] and Roxicodone[7] for pain. Respondent, notwithstanding the amount of controlled pain medications Patient A was getting through combined intrathecal and systemic drug therapies, also gave verbal orders for an intramuscular injection of Dilaudid[8] 4 mg for Patient A at this visit. Significantly, there was no observation period of Patient A following the pump's medication refill at this visit.

(e) Following a pump pocket fill of Patient A's intrathecal pump, Respondent sent her home after only one dose of Naloxone.[9] Significantly, Respondent failed to observe Patient A after this single dose and evaluate potential side-effects including, but not limited to, opioid over-dosage.

(f) In or around June 2015, Patient A was admitted for a prolonged admission to a hospital at the University of California San Diego (UCSD). During her admission, Patient A's intrathecal pump had to be filled with medication. A UCSD physician treating Patient A identified that the concentration of medication in her pump was "extremely high" and that the pump's internal computer listed the concentration of drugs in "milligrams," and not micrograms (mcg), even though mcg is the standard measurement of concentration of medication used in an intrathecal pump. Respondent personally verified the accuracy of the listed

---

[6] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] Roxicodone is a brand name for oxycodone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[8] Dilaudid is a brand name for hydromorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[9] Naloxone is a medication designed to rapidly reverse opioid overdose.

concentrations and infusion doses directly to the UCSD physician. A "formula sheet" containing a list of medication concentration was also faxed from Respondent's clinic to UCSD to again verify concentrations and dosages that the Respondent fills in Patient A's pump. The "formula sheet" clearly indicated that major discrepancies existed between its listed concentrations and dosages and the final concentrations actually contained in Patient A's pump.

(g) Respondent routinely issued prescriptions to Patient A for the concomitant use of addictive controlled pain medications including, but not limited to, MS Contin,[10] Roxicodone, benzodiazepines,[11] Soma,[12] and phentermine.[13] Prescriptions for this dangerous drug combination were issued to Patient A on multiple dates including, but not limited to, January 23, 2017; February 21, 2017; March 6, 2017; April 28, 2017; June 1, 2017; August 7, 2017; and October 2, 2017. Respondent failed to document his clinical judgment behind prescribing a controlled medication combination with potentially lethal consequences, which occurred every time he prescribed the concomitant use of these drugs to Patient A.

////

////

---

[10] MS Contin is a brand name for morphine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[11] Benzodiazepines are Schedule IV controlled substances pursuant to Health and Safety Code section 11057, subdivision (d), and are a dangerous drug pursuant to Business and Professions Code section 4022. Concomitant use of benzodiazepines with opioids may result in profound sedation, respiratory depression, coma, and/or death. The DEA has identified benzodiazepines as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 59.)

[12] Soma is a brand name for carisoprodol, which is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. The DEA has identified Soma as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 27.)

[13] Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. The DEA has identified phentermine as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2017 Edition), at p. 50.)

(h) From in or around 2011 to in or around 2017, Respondent, notwithstanding his knowledge of Patient A's documented history of drug and alcohol abuse and "drug seeking" behavior, continued to prescribe massive amounts of addictive controlled pain medication even after inconsistencies were discovered in her urine drug screens and Controlled Substance Utilization Review and Evaluation System[14] (CURES) reports indicating she had received controlled prescriptions from other physicians. The chart notes during this time frame fail to adequately document any discussion with Patient A about the reasons and/or explanations for these inconsistencies.

12. Respondent committed gross negligence in his care and treatment of patient A including, but not limited to, the following:

(a) Respondent, after initiation of intrathecal drug therapy, failed to reduce and/or eliminate Patient A's continued use of systemic opioid drug therapy;

(b) On or about October 9, 2012, Respondent initiated an excessive dose of fentanyl at an intended concentration of 25 mg/mL and a starting dose of 2.499 mg per day, in Patient A's intrathecal pump;

(c) On or about October 9, 2012, Respondent failed to initiate intrathecal therapy in an inpatient setting to observe whether Patient A had a safe response to the medication;

////

////

[14] The Controlled Substance Utilization Review and Evaluation System (CURES) is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III, and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) It is important to note that the history of controlled substances dispensed to a specific patient based on the data contained in CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

(d) On or about October 9, 2012, Respondent failed to initiate intrathecal therapy in an outpatient setting to observe whether Patient A had a safe response to the medication;

(e) On or about October 9, 2012, Respondent gave verbal orders for an intramuscular injection of Dilaudid 4 mg for Patient A despite the amount of controlled pain medications Patient A was already receiving through combined intrathecal drug therapy and systemic drug therapy;

(f) Respondent performed a pump pocket fill of Patient A's intrathecal pump, and, after administering a single dose of Naloxone, he failed to observe and evaluate the patient for potential side-effects of opioid over-dosage;

(g) Respondent failed to maintain adequate and accurate records by failing to accurately record information about medication used in Patient A's intrathecal pump, including, but not limited to, starting concentration of medication, final concentration of medication, starting and final concentration of medication after other medication was added, drug calculations, and other reported values of concentration and doses;

(h) Respondent failed to properly program medication information into Patient A's intrathecal pump, including, but not limited to, starting concentration of medication, final concentration of medication, starting and final concentration of medication after other medication was added; and other reported values of concentration and doses;

(i) Respondent repeatedly and clearly excessively prescribed, furnished, dispensed, and/or administered opioids to patient A;

(j) Respondent routinely prescribed dangerous drug combinations and doses to Patient A including, but not limited to, MS Contin, Roxicodone, benzodiazepines, Soma, and phentermine;

////

(k) Respondent failed to document his clinical judgment behind prescribing a controlled medication combination for concomitant use by Patient A with potentially lethal consequences; and

(l) Respondent, with knowledge of Patient A's documented drug seeking behavior, failed to provide appropriate treatment in that he, among other things, repeatedly prescribed excessive amounts of addictive pain medication to Patient A over an extended period of time, while failing to respond to objective signs of aberrant drug behavior.

13. **Patient B**

(a) Between in or around 2004 and in or around November 2013, Patient B treated with Respondent for pain management due to a number of medical issues including, degenerative disc disease and chronic low back pain.[15] On or about April 19, 2015, Patient B died of a drug overdose. The medical examiner's autopsy report determined his cause of death was from "mixed medication intoxication (fentanyl, oxycodone, oxymorphone, and diazepam)."

(b) Between in or around 2011 and in or around 2013, Respondent prescribed Patient B escalating doses of opioids in combination with other controlled drugs, including, but not limited to, benzodiazepines, antidepressants, muscle relaxants, and testosterone. In fact, Respondent prescribed excessive amounts of opioids including, but not limited to, on or about October 1, 2013, issuing a prescription for Roxicodone (30mg) (#140) amounting to approximately ten (10) tablets daily. Significantly, this prescription alone equaled an incredibly high four hundred fifty (450) MME.

(c) From in or around 2011 to in or around 2013, Respondent, notwithstanding his knowledge of Patient B's documented history of opioid

[15] Conduct occurring more than seven (7) years from the filing date of the initially filed Accusation (April 27, 2018) involving Patient B is for informational purposes only and is not alleged as a basis for disciplinary action.

dependence, alcohol and drug abuse, depression, and other aberrant drug behaviors, continued prescribing large amounts of addictive medication even after numerous inconsistencies were discovered in Patient B's urine drug screens and CURES reports, including, but not limited to, June 23, 2011 (inconsistent for Vicodin and Valium); March 14, 2013 (misused prescription); April 16, 2013 (misused prescription); and August 14, 2013 (+cocaine). The chart notes during this time frame fail to adequately document any discussion with Patient B about the reasons and/or explanations for these inconsistencies. Although Patient B's medications were discontinued on occasion due to non-compliance, the prescriptions were later continued with similar dosing strength and frequency. Significantly, Respondent failed to document any discussion with Patient B regarding a referral to addictionology or a rehabilitation facility despite multiple "red flags" involving drug abuse and depression.

(d) In a chart note dated November 29, 2012, it was documented that Patient B requested a different dosage of medication in order to help with his depression. At the next charted visit, on or about January 15, 2013, there is no documentation of a follow up on Patient B's request for a different dosage. However, it is documented that he has been experiencing increased anxiety but with no further comment or follow up charted in the note.

(e) There are missing chart notes for July, August, and September 2013. However, Patient B filled controlled prescriptions issued by Respondent during this time frame. In addition, there are chart notes documenting conflicting information regarding what medication was being prescribed and taken.

14. Respondent committed gross negligence in his care and treatment of Patient B including, but not limited to, the following:

(a) Respondent prescribed excessive amounts of opioids including, but not limited to, on or about October 1, 2013, issuing a prescription for Roxicodone (30mg) (#140) amounting to approximately ten (10) tablets daily;

(b) Respondent failed to effectively monitor and manage Patient B's drug use by continuing to prescribe addictive controlled medication after years of inconsistent drug tests, positive test result for cocaine, and/or repeated misuse of controlled prescriptions;

(c) Respondent failed to refer Patient B to addictionology or rehabilitation facility after repeated "red flags" of aberrant drug behavior;

(d) There are missing chart notes for July, August, and September 2013; and

(e) There are multiple inaccurate chart notes documenting conflicting information regarding what medication was being prescribed and taken.

15. **Patient C**

(a) Between in or around 2008 and in or around 2012, Patient C treated with Respondent for pain management due to chronic pain from a work related injury.[16] On or about July 22, 2012, Patient C died of a drug overdose. The medical examiner's autopsy report determined her cause of death was from "acute oxycodone, carisoprodol, and diazepam intoxication."

(b) Between in or around 2011 and in or around 2012, Respondent managed Patient C on many different medication classes for her drug therapy including, but not limited to, opioids (long acting and short acting), multiple benzodiazepines, neuropathic pain medication, multiple muscle relaxants at same time, and antiemetics. In fact, Respondent prescribed an excessive number of drugs that performed same or similar mechanisms of action to treat Patient C.

(c) Patient C's medical charts failed to include a review of systems, failed to consistently include a well-defined chief complaint, and failed to accurately record information regarding prescribed medication. In addition, there were no

////

[16] Conduct occurring more than seven (7) years from the filing date of the initially filed Accusation (April 27, 2018) involving Patient C is for informational purposes only and is not alleged as a basis for disciplinary action.

CURES reports contained in Patient C's medical records nor any mention in her charts of checking CURES for patient compliance.

16. Respondent committed gross negligence in his care and treatment of Patient C including, but not limited to, the following:

(a) Respondent prescribed an excessive number of controlled drugs, including, but not limited to, opioids (long acting and short acting), benzodiazepines, muscle relaxers, and antiemetics to treat Patient C.

17. **Patient D**

(a) Between in or around December 2011, and in or around July 2012, Patient D treated with Respondent for pain management due to chronic pain.[17] On or about August 1, 2012, Patient D died of a drug overdose. The medical examiner's autopsy report determined her cause of death was from "acute tapentadol, fentanyl, and alprazolam intoxication."

(b) During the time that Patient D was under the care of Respondent, she was morbidly obese; she had a long history of poor pulmonary function and pulmonary disease; and she had a documented history of opioid dependence. Significantly, she had a long and documented history of multiple Emergency Department and hospital admissions for various medical conditions, including hospitalizations due to opioid induced respiratory depression.[18]

(c) On or about November 23, 2011, Patient D visited an Emergency Department and had requested a medication refill because her pain management doctor was "out of town." The medical record of that visit documented that Patient D's pain management doctor at the time, Dr. A.S., was contacted and that she had contradicted the patient's account regarding lack of medication.

---

[17] Conduct occurring more than seven (7) years from the filing date of the First Amended Accusation involving Patient D is for informational purposes only and is not alleged as a basis for disciplinary action.

[18] In 2011 and 2012, Patient D had multiple admissions to Emergency Departments and hospitals.

Furthermore, Dr. A.S. advised Emergency Department staff that she had been having difficulty with managing Patient D's pain due to the patient's "concomitant illicit drug use." Patient D was denied opioid medication from Emergency Department medical staff that day. Three days later, Patient D returned to the same Emergency Department and requested to be admitted for drug detoxification.

(d) On or about December 23, 2011, Respondent had his initial examination with Patient D. In the chart note for this visit, Respondent documented that "[Patient D] had leftover methadone from a *few years* ago and began taking due to the fact she was out of Oxy IR ... [Patient D] states she last took methadone this morning."

(e) Between in or around December 2011 and in or around July 2012, Respondent managed Patient D on many different medication classes for her drug therapy including, but not limited to, opioids, benzodiazepines, muscle relaxants, and anti-seizure medication at the same time.

(f) Significantly, Patient D's medical charts from Respondent's clinic do not contain any information about her vitals being taken at each clinical visit. In addition, the charts also do not include a review of systems and/or a well-defined chief complaint. Furthermore, the charts do not accurately record information regarding Patient D's past and then-currently prescribed controlled medication. Finally, Respondent prescribed Patient D large amounts of opioids without adequately documenting her past hospitalizations involving poor pulmonary function and pulmonary disease.

(g) In a chart note dated July 26, 2012, Respondent documented that Patient D had wanted to switch pain medications, namely, replace Dilaudid with Nucynta,[19] because she had reported that Nucynta was more effective for her pain

[19] Nucynta is a brand name for tapentadol, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

control. Respondent, notwithstanding Patient D's current dosages of the transdermal Fentanyl patch[20] along with other opioids, issued her a prescription for Nucynta (100mg) (#228).[21] The Nucynta prescription alone resulted in an increase of more than one hundred fifty (150) MME being taken by Patient D at that time.[22]

18. Respondent committed gross negligence in his care and treatment of Patient D including, but not limited to, the following:

(a) On or about July 26, 2012, Respondent prescribed an excessive amount of opioids when he issued Patient D a prescription for Nucynta (100mg) (#228); and

(b) Respondent failed to accurately record critical information in Patient D's medical record, including, but not limited to, failed to have vital signs taken and/or documented at each visit; failed to accurately record information regarding Patient D's past and then-currently prescribed controlled medication; and failed to document a review of systems and/or a well-defined chief complaint.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

19. Respondent has further subjected his Physician's and Surgeon's Certificate No. G66777 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of patients A, B, C, D, and E,[23] as more particularly alleged hereinafter:

---

[20] Transdermal fentanyl (Duragesic) patches are applied to the skin; used to relieve severe pain, the patch is usually applied to the skin once every 72 hours. Fentanyl patches may cause serious or life-threatening breathing problems. Taking certain medications (e.g., benzodiazepines and muscle relaxants) with fentanyl may increase the risk of serious or life-threatening breathing problems, sedation, or coma.

[21] Patient D's prescribed regimen of opioids represented a total of three hundred ninety-five (395) MME.

[22] Patient D had recently filled prescriptions for Dilaudid (Hydromorphone HCL) on July 10, 2012 (4mg) (#180), and on June 13, 2012 (4mg) (#180).

[23] Letter E is used for the purposes of maintaining patient confidentiality.

20. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

21. **Patient B**

(a) Paragraphs 13 and 14, above, are hereby incorporated by reference and realleged as if fully set forth herein.

22. **Patient C**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) There are no CURES reports in Patient C's medical records nor any mention of checking CURES for patient compliance;

(c) In 2012, Respondent prescribed two (2) muscle relaxants at same time to Patient C; and

(d) Patient C's medical charts failed to include a review of systems; failed to consistently include a well-defined chief complaint; and failed to accurately record information regarding prescribed medication.

23. **Patient D**

(a) Paragraphs 17 and 18, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Patient D's medical charts failed to include and/or document any information regarding Patient D's past multiple hospitalizations.

24. **Patient E**

(a) Between in or around April 2013, and in or around October 2013, Patient E treated with Respondent for pain management due to low back pain.[24] On or about December 15, 2013, Patient E died of a drug overdose. The medical

[24] Conduct occurring more than seven (7) years from the filing date of the First Amended Accusation involving Patient D is for informational purposes only and is not alleged as a basis for disciplinary action.

examiner's autopsy report determined his cause of death was from "acute bronchopneumonia; contributing: chronic prescription medication abuse with acute oxycodone and alcohol intoxication; pulmonary emphysema; hepatic cirrhosis."

(b) Between in or around April 2013, and in or around October 2013, Respondent managed Patient E on high dosages of opioids and benzodiazepines at the same time.

(c) In a chart note dated June 26, 2013, it was documented that a prescription was issued to Patient E to obtain a urine drug screen (UDS). The results of the UDS later indicated that Patient E was "negative" for benzodiazepines, despite being prescribed that drug by Respondent. However, Respondent never required Patient E to get another UDS and/or other confirmatory screen to confirm that he was taking the controlled medications being prescribed to him. Instead, Respondent continued to issue prescriptions for controlled pain medication to Patient E without documenting in the medical record any information and/or discussion with Patient E about the inconsistent UDS results.

(d) Patient E had a history of illicit drug use. However, Respondent never discussed and/or documented any discussion with Patient E in the medical record about any past history of illicit drug use.

25. Respondent committed repeated negligent acts in his care and treatment of Patient E including, but not limited to, the following:

(a) Respondent failed to require Patient E to get another UDS and/or other confirmatory screen to confirm that he was taking the controlled medications that Respondent had been prescribing to him; and

(b) Respondent failed to document in the medical record any discussion with Patient E about any past history of illicit drug use.

////

////

////

////

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

26. Respondent has further subjected his Physician's and Surgeon's Certificate No. G66777 to disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (d), of the Code, in that Respondent demonstrated incompetence in his care and treatment of patient A, as more particularly alleged hereinafter:

27. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

28. Respondent has further subjected his Physician's and Surgeon's Certificate No. G66777 to disciplinary action under sections 2227 and 2234, as defined in section 725, of the Code, in that Respondent has committed repeated acts of clearly excessive prescribing drugs or treatment to patients A, B, and C, as determined by the standard of the community of physicians and surgeons, as more particularly alleged hereinafter:

29. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

30. **Patient B**

(a) Paragraphs 13 and 14, above, are hereby incorporated by reference and realleged as if fully set forth herein.

31. **Patient C**

(a) Paragraphs 15 and 16, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

32. Respondent has further subjected his Physician's and Surgeon's Certificate

No. G66777 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records in connection with his care and treatment of patients A, B, C, D, and E, as more particularly alleged hereinafter:

33. **Patient A**

(a) Paragraphs 11 and 12, above, are hereby incorporated by reference and realleged as if fully set forth herein.

34. **Patient B**

(a) Paragraphs 13 and 14, above, are hereby incorporated by reference and realleged as if fully set forth herein.

35. **Patient C**

(a) Paragraphs 15 and 22, above, are hereby incorporated by reference and realleged as if fully set forth herein.

36. **Patient D**

(a) Paragraphs 17, 18, and 23, above, are hereby incorporated by reference and realleged as if fully set forth herein.

37. **Patient E**

(a) Paragraphs 24 and 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

38. Respondent has further subjected his Physician's and Surgeon's Certificate No. G66777 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 10 through 37, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

////

////

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's License No. G66777, issued to Respondent David James Smith, M.D.;

2. Revoking, suspending or denying approval of Respondent David James Smith, M.D.'s, authority to supervise physician assistants and/or advanced practice nurses;

3. Ordering Respondent David James Smith, M.D., to pay the Medical Board of California the costs of probation monitoring, if placed on probation; and

4. Taking such other and further action as deemed necessary and proper.

DATED: February 13, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SD2017802855
Doc.No.71736994